**National Quality Forum—Evidence (subcriterion 1a)**

**Measure Number** (*if previously endorsed*)**:** N/A

**Measure Title**: PointRight OnPoint-30 SNF Rehospitalizations

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** Click here to enter composite measure #/ title

**Date of Submission**: 2/5/2014

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| **Instructions**  *For composite performance measures:*  *A separate evidence form is required for each component measure unless several components were studied together.*  *If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.*   * Respond to all questions as instructed with answers immediately following the question. All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed. * If you are unable to check a box, please highlight or shade the box for your response. * Maximum of 10 pages (*incudes questions/instructions*; minimum font size 11 pt; do not change margins). ***Contact NQF staff if more pages are needed.*** * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

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| **Note: The information provided in this form is intended to aid the Steering Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF’s evaluation criteria.**   1a. Evidence to Support the Measure Focus The measure focus is evidence-based, demonstrated as follows:   * Health outcome: [**3**](#Note3) a rationale supports the relationship of the health outcome to processes or structures of care. Applies to patient-reported outcomes (PRO), including health-related quality of life/functional status, symptom/symptom burden, experience with care, health-related behavior. * Intermediate clinical outcome: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4)that the measured intermediate clinical outcome leads to a desired health outcome. * Process: [**5**](#Note5) a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured process leads to a desired health outcome. * Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured structure leads to a desired health outcome. * Efficiency: [**6**](#Note6) evidence not required for the resource use component.   **Notes**  **3.** Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.  **4.** The preferred systems for grading the evidence are the U.S. Preventive Services Task Force (USPSTF) [grading definitions](http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm) and [methods](http://www.uspreventiveservicestaskforce.org/methods.htm), or Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org/publications/index.htm).  **5.** Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement. Note: A measure focused only on collecting PROM data is not a PRO-PM.  **6.** Measures of efficiency combine the concepts of resource use and quality (see NQF’s [Measurement Framework: Evaluating Efficiency Across Episodes of Care](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx); [AQA Principles of Efficiency Measures](http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc)). |

**1a.1.This is a measure of**: (*should be consistent with type of measure entered in De.1*)

Outcome

Health outcome: SNF Rehospitalizations

Patient-reported outcome (PRO): Click here to name the PRO

*PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors*

Intermediate clinical outcome (*e.g., lab value*): Click here to name the intermediate outcome

Process: Click here to name the process

Structure: Click here to name the structure

Other: Click here to name what is being measured

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**HEALTH OUTCOME/PRO PERFORMANCE MEASURE**  *If not a health outcome or PRO, skip to* [*1a.3*](#Section1a3)

**1a.2.** **Briefly state or diagram the path between the health outcome (or PRO) and the healthcare structures, processes, interventions, or services that influence it.**

Rehospitalizations of any cause among individuals admitted to a skilled nursing facility (SNF) is the result of numerous clinical and non-clinical situations (Ouslander, 2012). The pathway leading to rehospitalizations is complex and differs for when the rehospitalization occurs after admission. However, a combination of structure, process and interventions influence the likelihood of rehospitalizations more than patient acuity and condition (Ouslander, 2012; Young et al., 2011). For early rehospitalizations following transfers from a hospital to a SNF, structural causes such as lack of equipment or medications upon arrival to the SNF often lead to rapid rehospitalizations. Inadequate information on transfer from the hospital to the SNF is another contributor for early rehospitalizations. For rehospitalizations occurring several days after transfer, structural causes such as those related to staffing levels (e.g., 24 RN presence) and type (e.g. nurse practitioner availability) are associated with lower rehospitalization rates. Processes and interventions such as early detection of signs and symptoms of impending infections (pneumonia, UTI, etc.) and chronic disease exacerbation (e.g. CHF, DM, etc.) can help reduce rehospitalizations. Inadequate adherence to treatment interventions and protocols for such conditions as pneumonia or UTI also lead to rehospitalizations. Ineffective communication between the RN and attending physician also commonly leads to rehospitalizations. Lack of discussion about end-of-life preferences including Do Not Hospitalize preferences lead to more rehospitalizations than necessary.

Oslander, J.G., & Maslow, K. (2012). Geriatrics and the triple aim: Defining preventable hospitalizations in the long-term care population. *J Am Geriatr Soc.*, 60(12): 2313-2318.

Young, Y., Inamdar, S., Dichter, B.S., Kilburn, H., & Hannan, E.L. (2011). Clinical and nonclinical factors associated with potentially preventable hospitalizations among nursing home residents in New York state. *JAMDA*, 5: 364-371.

**1a.2.1.** **State the rationale supporting the relationship between the health outcome (or PRO) to at least one healthcare structure, process, intervention, or service (*i.e., influence on outcome/PRO*).**

A large portion of the rehospitalizations have hospital admission diagnoses suggesting that better clinical management in the SNF may have prevented the rehospitalization (Halfon et al., 2006; Spector, 2013; Walker, 2009). Following expert physician review of cases, many of the rehospitalizations are felt to be preventable and are often a result of the lack of early detection of the patient’s clinical deterioration by SNF staff (Saliba ,2000; Ouslander, 2010). In addition, adequacy of information upon transfer from the hospital to the SNF (Brook, 2013), the availability of information to physicians and SNFs (MedPac, 2012); the communication between the SNF staff and the attending physician (Ouslander, 2011) and discussions about end of life (Berkowitz, 2011) have all been shown as significant contributors to higher rehospitalizations from SNF.

Berkowitz, R.E., Jones, R.N., Rieder, R., Bryan, M., Schreiber, R., Verney, S., & Paasche-Orlow, M.K. (2011). Improving disposition outcomes for patients in a geriatric nursing facility. *J Am Geriatr Soc.*, 59: 1130-1136.

Brock, J., Mitchell, J., Irby, K., Stevens, B., Archibald, T., Goroski, A., & Lynn, J. (2013). Association between quality improvement for care transitions in communities and rehospitalizations among Medicare beneficiaries. *JAMA*, 309(4).

Halfon, P., Eggli, Y., Pretre-Rohrback, I., Meylan, D., Marazzi, A., & Burnand, B. (2006). Validation of the potentially avoidable hospital readmission rate as a routine indicator of the quality of hospital care. *Medical Care*, 44(11): 972-981.

MedPAC. (2012) Report to congress: Payment policy. <http://medpac.gov/documents/mar12_entirereport.pdf>

Ouslander, J.G., Lamb,G., Tappen, R., Herndon, L., Diaz, S., Roos, B.A., … Bonner, A. (2011). Interventions to reduce hospitalizations from nursing homes: Evaluation of the INTERACT II collaborative quality improvement project. *J Am Geriatr Soc*., 59(4): 745-753.

Saliba, D., Kington, R., Buchanan, J., Bell, R., Wang, M., Lee, M., …Rubenstein, L. (2000). Appropriateness of the decision to transfer nursing facility residents to the hospital. *J Am Geriatr Soc.*, 48(2): 154-163.

Spector, W.D., Limcangco, R., Williams, C., Rhodes, W., & Hurd, D. (2013). Potentially Avoidable Hospitalizations for Elderly Long-stay residents in nursing homes. *Medical Care*, 51(8):673-681.

Walker, J.D., Teare, G.F., Hogan, D.B., Lewis, S., & Maxwell, C.J. (2009). Identifying potentially avoidable hospital admissions form Canadian long-term care facilities. *Medical Care*, 47(2):250-254.

*Note: For health outcome/PRO performance measures, no further information is required; however, you may provide evidence for any of the structures, processes, interventions, or service identified above.*

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**intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measure**

**1a.3.****Briefly state or diagram the path between structure, process, intermediate outcome, and health outcomes**. Include all the steps between the measure focus and the health outcome.

**1a.3.1.** **What is the source of the systematic review of the body of evidence that supports the performance measure?**

Clinical Practice Guideline recommendation – ***complete sections*** [***1a.4***](#Section1a4)***, and*** [***1a.7***](#Section1a7)

US Preventive Services Task Force Recommendation – ***complete sections*** [***1a.5***](#Section1a5) ***and*** [***1a.7***](#Section1a7)

Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*) – ***complete sections*** [***1a.6***](#Section1a6) ***and*** [***1a.7***](#Section1a7)

Other – ***complete section*** [***1a.8***](#Section1a8)

*Please complete the sections indicated above for the source of evidence. You may skip the sections that do not apply.*

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**1a.4. CLINICAL PRACTICE GUIDELINE RECOMMENDATION**

**1a.4.1.** **Guideline citation** (*including date*) and **URL for guideline** (*if available online*):

**1a.4.2.** **Identify guideline recommendation number and/or page number** and **quote verbatim, the specific guideline recommendation**.

**1a.4.3.** **Grade assigned to the quoted recommendation with definition of the grade:**

**1a.4.4. Provide all other grades and associated definitions for recommendations in the grading system.** (*Note: If separate grades for the strength of the evidence, report them in section 1a.7.*)

**1a.4.5. Citation and URL for methodology for grading recommendations** (*if different from 1a.4.1*)**:**

**1a.4.6. If guideline is evidence-based (rather than expert opinion), are the details of the quantity, quality, and consistency of the body of evidence available (e.g., evidence tables)?**

Yes **→ *complete section*** [***1a.7***](#Section1a7)

No **→ *report on another systematic review of the evidence in sections*** [***1a.6***](#Section1a6) ***and*** [***1a.7***](#Section1a7)***; if another review does not exist, provide what is known from the guideline review of evidence in*** [***1a.7***](#Section1a7)

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**1a.5.** **UNITED STATES PREVENTIVE SERVICES TASK FORCE RECOMMENDATION**

**1a.5.1.** **Recommendation citation** (*including date*) and **URL for recommendation** (*if available online*):

**1a.5.2.** **Identify recommendation number and/or page number** and **quote verbatim, the specific recommendation**.

**1a.5.3.** **Grade assigned to the quoted recommendation with definition of the grade**:

**1a.5.4. Provide all other grades and associated definitions for recommendations in the grading system.** (*Note: the* *grading system for the evidence should be reported in section 1a.7.*)

**1a.5.5. Citation and URL for methodology for grading recommendations** (*if different from 1a.5.1*)**:**

***Complete section*** [***1a.7***](#Section1a7)

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**1a.6. OTHER SYSTEMATIC REVIEW OF THE BODY OF EVIDENCE**

**1a.6.1.** **Citation** (*including date*) and **URL** (*if available online*):

**1a.6.2.** **Citation and** **URL for methodology for evidence review and grading** (*if different from 1a.6.1*)**:**

***Complete section*** [***1a.7***](#Section1a7)

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**1a.7. FINDINGS FROM SYSTEMATIC REVIEW OF BODY OF THE EVIDENCE supporting the measure**

*If more than one systematic review of the evidence is identified above, you may choose to summarize the one (or more) for which the best information is available to provide a summary of the quantity, quality, and consistency of the body of evidence. Be sure to identify which review is the basis of the responses in this section and if more than one, provide a separate response for each review.*

**1a.7.1.** **What was the specific structure, treatment, intervention, service, or intermediate outcome addressed in the evidence review?**

**1a.7.2.** **Grade assigned for the quality of the quoted evidence with definition of the grade**:

**1a.7.3. Provide all other grades and associated definitions for strength of the evidence in the grading system.**

**1a.7.4.** **What is the time period covered by the body of evidence? (*provide the date range, e.g., 1990-2010*). Date range**: Click here to enter date range

**QUANTITY AND QUALITY OF BODY OF EVIDENCE**

**1a.7.5.****How many and what type of study designs are included in the body of evidence**? (*e.g., 3 randomized controlled trials and 1 observational study*)

**1a.7.6.** **What is the overall quality of evidence across studies in the body of evidence**? (*discuss the certainty or confidence in the estimates of effect particularly in relation to study factors such as design flaws, imprecision due to small numbers, indirectness of studies to the measure focus or target population*)

**ESTIMATES OF BENEFIT AND CONSISTENCY ACROSS STUDIES IN BODY OF EVIDENCE**

**1a.7.7.** **What are the estimates of benefit—magnitude and direction of effect on outcome(s) across studies in the body of evidence**? (*e.g., ranges of percentages or odds ratios for improvement/ decline across studies, results of meta-analysis, and statistical significance*)

**1a.7.8.** **What harms were studied and how do they affect the net benefit (benefits over harms)?**

**UPDATE TO THE SYSTEMATIC REVIEW(S) OF THE BODY OF EVIDENCE**

**1a.7.9.** **If new studies have been conducted since the systematic review of the body of evidence, provide for each new study: 1) citation, 2) description, 3) results, 4) impact on conclusions of systematic review**.

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**1a.8 OTHER SOURCE OF EVIDENCE**

*If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.*

**1a.8.1** **What process was used to identify the evidence?**

Support for this kind of outcome measure is readily available in the current use of rehospitalization measures by federal and other health care agencies. SNF rehospitalization is used currently by federal agencies such as MedPAC and CMS to measure quality of SNF care (MedPac, 2012; Walsh, 2010). Respected foundations and non-profit organizations such as Kaiser Family Foundation and Commonwealth Fund use SNF rehospitalizations as measure of quality (Jacobson, 2010; Schoen, 2013). In addition, ASPE and Long Term Care Quality Alliance both have conducted reviews of potential measures of hospitalization from SNFs (Polniaszek, 2011; Young, 2011). These measures were reviewed and vendors providing measures to long term care providers were also approached and their measures reviewed.

Jacobson, G., Neuman, T., & Damico, A. (2010). Medicare spending and use of medical services for beneficiaries in nursing homes and other long term care facilities: A potential for achieving Medicare saving and improving the quality of care. *The Henry J. Kaiser Family Foundation*.

MedPAC. (2012) Report to congress: Payment policy. <http://medpac.gov/documents/mar12_entirereport.pdf>

Polniaszek, S., Walsh, E.G., & Wiener, J.M. (2011). Hospitalizations of nursing home residents: Background and options. *Office of the Assistant Secretary for Planning and Evaluation,* <http://aspe.hhs.gov/daltcp/reports/2011/NHResHosp.pdf>

Schoen, C., Radley, D., Riley, P., Lippa, J., Berenson, J., Dermody, C., & Shih A. (2013). Health Care in the two Americas: Findings from the scorecard on the state health system performance for low-income populations. *The Commonwealth Fund*. <http://www.commonwealthfund.org/Publications/Fund-Reports/2013/Sep/Low-Income-Scorecard.aspx>

Walsh, E.D., Freiman, M., Haber, S., Bragg, A., Ouslander, J., & Wiener, J.M. (2010). Cost drivers for dually eligible beneficiaries: Potentially avoidable hospitalization from nursing facility, skilled nursing facility, and home and community-based services waiver programs, final task 2 report. *RTI International*.

Young, H.M., Kurtzman, E., Roes, M., Toles, M., Ammerman, A., & Pace, D. (2011). Measurement opportunities & gaps: Transitional care processes and outcomes among adult recipients of long-term services and supports. *Long Term Quality Alliance, Quality Measurement Workgroup*.

**1a.8.2.** **Provide the citation and summary for each piece of evidence.**

Most all of the measures of rehospitalization were being used for policy decisions by MedPAC or CMS (MedPAC, 2012; Walsh, 2010), or as population measures (Jacobson, 2010; Schoen, 2013) or in academic publications as policy evaluations about the quality of care received by nursing home residents (Grabowski, 2007; Clark, 2010; Mor, 2010; Walsh, 2010). None had used as a measure specifically to evaluate performance of an individual provider.

Often the measures evaluated rehospitalizations for potentially avoidable conditions based on AHRQ’s ambulatory sensitive conditions. However, LTQA recommended using an all cause readmission measure (Young, 2011). Studies examining the causes of readmissions to hospitals for the three current CMS hospital readmission measures found that most were unrelated to the discharge diagnosis (Dharmarajan, 2013). In addition, most of the reasons for high rehospitalizations from SNFs have been attributed to structural and process reasons not directly related to the clinical management of the patient’s diagnoses listed on the hospital readmission claim (Ouslander, 2012). This suggests that efforts to reduce rehospitalizations that focus on structural and process related issues will reduce both potentially avoidable causes and all other causes (Ouslander, 2010; Ouslander, 2011). Based on this evidence, we proposed to develop an all cause readmission measure from the SNF rather than a measure restricted to potentially avoidable causes.

Dharmarajan, K., Hsieh, A., Lin A., Bueno, H., Ross, J.S., Horwitz, L., … Hines, H.J. (2013). Hospital readmission performance and patterns of readmission: Retrospective cohort study of Medicare admissions. *BMJ*, 347.

Jacobson, G., Neuman, T., & Damico, A. (2010). Medicare spending and use of medical services for beneficiaries in nursing homes and other long term care facilities: A potential for achieving Medicare saving and improving the quality of care. *The Henry J. Kaiser Family Foundation*.

MedPAC. (2012) Report to congress: Payment policy. <http://medpac.gov/documents/mar12_entirereport.pdf>

Mor, V., Intrator, O., Feng, Z., & Grabowski, D.C. (2010). The revolving door of rehospitalizations from skilled nursing facilities. *Health Affairs*, 29(1): 57-64.

Ouslander, J.G., & Bersenson, R.A. (2011). Reducing unnecessary hospitalization of nursing home residents. *NEJM*, 356(13): 1165-1167.

Ouslander, J.G., Lamb, G., Perloe, M., Givens, J.H., Kluge, L., Rutland, T, … Saliba, D. (2010). Potentially avoidable hospitalizations of nursing home residents: Frequency, causes, and costs. *J Am Geriatr Soc.*, 58(4): 627-635.

Ouslander, J.G., Lamb,G., Tappen, R., Herndon, L., Diaz, S., Roos, B.A., … Bonner, A. (2011). Interventions to reduce hospitalizations from nursing homes: Evaluation of the INTERACT II collaborative quality improvement project. *J Am Geriatr Soc.*, 59(4): 745-753.

Schoen, C., Radley, D., Riley, P., Lippa, J., Berenson, J., Dermody, C., & Shih A. (2013). Health Care in the two Americas: Findings from the scorecard on the state health system performance for low-income populations. *The Commonwealth Fund*. <http://www.commonwealthfund.org/Publications/Fund-Reports/2013/Sep/Low-Income-Scorecard.aspx>

Walsh, E.D., Freiman, M., Haber, S., Bragg, A., Ouslander, J., & Wiener, J.M. (2010). Cost drivers for dually eligible beneficiaries: Potentially avoidable hospitalization from nursing facility, skilled nursing facility, and home and community-based services waiver programs, final task 2 report. *RTI International*.

Young, H.M., Kurtzman, E., Roes, M., Toles, M., Ammerman, A., & Pace, D. (2011). Measurement opportunities & gaps: Transitional care processes and outcomes among adult recipients of long-term services and supports. *Long Term Quality Alliance, Quality Measurement Workgroup*